ADDITIONAL CLASS OF DISPROPORTIONATE SHARE PAYMENTS

Effective July 1, 1999, the Department established an additional class of disproportionate share payments to certain hospitals which the Department has determined provide a high volume of services related to MA births

In addition to meeting the criteria set forth in Part 1 of this state plan, for a hospital to qualify for an additional class of disproportionate share payment, the hospital must meet all of the following criteria:

(a) The hospital is enrolled as an acute care general hospital (provider type 11); and

(b) The hospital is located in a Federal Empowerment Zone; and

(c) In Calendar Year 1996, the hospital had more than 3,500 fee-for-service MA claims; and

(d) In Calendar Year 1996, more than 25% of the hospital's overall fee-for-service MA claims were related to MA births (specifically, DRGs 370 through 375 and 385 through 391).

The Department has allocated $3.5 million from the State General Fund for this additional class of disproportionate share payments.

Payments will be divided proportionately between qualifying hospitals based on the percentage of each qualifying hospital's fee-for-service MA births to total fee-for-service MA births of all qualifying facilities. All payment limitation are still applicable, namely, the Commonwealth will not exceed its aggregate annual disproportionate share allotment, and no hospital will receive disproportionate share payments in excess of its hospital-specific limit.

Private Psychiatric Hospitals and Distinct Part Psychiatric Units of Acute Care General Hospitals

General Policy

The Department pays for inpatient psychiatric services under a prospective payment system. Payment is made on a per diem basis. The prospective per diem rate for each provider is established using that provider's [illegible]

All compensable services provided to an inpatient are covered by the prospective per diem rate except for direct care services provided by salaried practitioners who bill the MA program directly.

Costs are determined using Medicare principles unless otherwise specified. The Department does not follow the substance or retroactivity of the malpractice insurance cost rule established by 51 F.R. 11142 (April 1, 1986). Malpractice insurance costs are included in the administrative and general cost center and allocated according to established accounting procedures.

Payment Limits

The Department's payment for inpatient services (including acute care general hospitals and their distinct part units, private psychiatric hospitals, and freestanding rehabilitation hospitals) may not exceed in the aggregate the amount that would be paid for those services under Medicare principles of reimbursement.

The Department's payment, exclusive of any disproportionate share payment adjustment, may not exceed the hospital's customary charges to the general public for the services.

The Department limits payments to inpatient psychiatric facilities to $950 per day through December 31, 1994. For the period January 1, 1995 to June 30, 1995, the payment limit will be increased by the inflation factor described subsequently, applicable to January 1, 1995.

Nonallowable Capital Costs

Capital costs for new or additional inpatient psychiatric beds are not allowable under the Medical Assistance Program unless a Section 1122 approval letter, a Certificate of Need, or a letter of nonreviewability had been issued for the additional beds by the Department of Health prior to July 1, 1991.

Capital costs related to replacement beds are not allowable unless the facility received a Certificate of Need or letter of nonreviewability for the replacement beds. To be allowable, the replacement beds must physically [illegible] and must have been recognized as allowable.

In addition to the above criteria, to receive payment for capital costs related to new, additional or replacement beds, the project must have been substantially implemented within the effective period of the original Section 1122 approval or the original Certificate of Need, including one six-month extension.

Calculation of Prospective Per Diem Rate

The prospective per diem rate of each private psychiatric hospital and distinct part psychiatric unit of an acute general hospital will be determined as follows:

(a) The hospital or unit's reported Medical Assistance allowable inpatient costs from its Fiscal Year 1989-90 Cost Report (MA 336) are divided by its reported Medical Assistance inpatient psychiatric days.

(b) The amount determined under (a) is reduced by a 1.69% overreporting factor.

(c) The per diem cost determined in (b) will be inflated to the year for which the rate is being set using the following inflation factors:

(1) 5.3 percent to account for Fiscal Year 1990-91 inflation.

(2) 5.2 percent to account for Fiscal Year 1991-92 inflation.

(3) 4.6 percent to account for Fiscal Year 1992-93 inflation.

(4) 4.3 percent to account for Fiscal Year 1993-94 inflation.

This inflation factor is applied effective July 1, 1993, for all inpatient psychiatric facilities which qualified for a disproportionate share rate enhancement in Fiscal Year 1992-93. The inflation factor is applied effective January 1, 1994, for other inpatient psychiatric facilities.

(5) Effective January 1, 1995 through December 31, 1995, the amount determined under (c)(4) was increased by 3.7%.

(d) For an inpatient psychiatric provider whose first full fiscal year of operation under the Medical Assistance Program is subsequent to Fiscal Year 1989-90, the first full fiscal year of operation under the Medical Assistance Program will serve as its base year. The Department will pay full allowable Medical Assistance costs in the base year. Payment for subsequent years will be the audited costs trended forward from the base year using the inflation factors described under (c).

(e) The amounts determined under (c) are limited to $950 for the period July 1, 1993, to December 31, 1994. The limit for the period January 1, 1995, to June 30, 1995, is $950 increased by the inflation factor described under (c)(5).

Exclusions From the Prospective Psychiatric Payment System

(a) Inpatient psychiatric facilities which place a new capital project into service after the base year are entitled to payment for certain capital costs, provided the qualifying criteria are met:

(e) Effective January 1, 1995, the Department limits interim and final payment to rehabilitation providers to $985.15 per day through December 31, 1995.

Exclusions From the Prospective Psychiatric Payment System

(a) Inpatient psychiatric facilities which place a new capital project into service after the base year are entitled to payment for certain capital costs, provided the qualifying criteria are met:

(1) The costs related to the capital project must represent increases in the inpatient psychiatric facility's allowable depreciation and interest costs for a fixed asset that was entered in the inpatient psychiatric facility's fixed asset ledger in the year being audited.

(2) The costs must be attributable to a fixed asset that is:

(i) approved for Certificate of Need on or before June 30, 1991, in accordance with 28 Pa. Code Chapter 301 (relating to limitations on Federal Participation for capital expenditures) or 28 Pa. Code Chapter 401 (related to Certificate of Need program), or not subject to review for Certificate of Need as evidenced by a letter of nonreviewability dated on or before June 30, 1991; and

(ii) related to patient care in accordance with Medicare standards.

(b) In order for an inpatient psychiatric facility to qualify for an additional capital payment set forth in this section, the following criteria must also be met:

(1) The inpatient psychiatric facility's rate of increase in overall audited costs must exceed 15%.

(2) The inpatient psychiatric facility's rate of increase for allowable depreciation and interest must exceed its rate of increase for net operating costs.

(c) For Fiscal Years 1993-94 through December 31, 1995, for each inpatient psychiatric facility which requests an additional capital payment, the Department will audit its MA cost reports for the fiscal year for which the request is made, the prior fiscal year and all subsequent fiscal years for which additional capital payment is requested. To the extend that the facility is determined eligible to receive an additional capital payment under this section, the following applies:

(1) For each fiscal year the Department will compare the total Medical Assistance payments for inpatient psychiatric services paid to the inpatient psychiatric facility for that fiscal year (the "total payment") with the inpatient psychiatric facility's actual Medical Assistance costs for inpatient psychiatric services as determined at audit, including the allowable capital costs eligible under this section (the "actual costs").

(2) If the amount of actual costs exceeds the total payment, the Department pays the inpatient psychiatric facility the difference between the actual costs and the total payment, not to exceed the amount of allowable capital costs.

(3) If the amount of actual costs does not exceed the total payment, the Department does not pay the inpatient psychiatric facility any additional capital payment.

(4) The Department will not recoup or offset any additional capital payment made under this section.

ADDITIONAL DISPROPORTIONATE SHARE PAYMENT

The methodology used by the Commonwealth to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid and medical assistance eligible, low income patients, including those eligible for general assistance, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below and are made in addition to, and not as a substitute for, disproportionate share payments described in other portions of this state plan.

These additional payment adjustments are made by either the Commonwealth directly or through an intermediary. The additional payment adjustments are paid to disproportionate share hospitals which have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State's General Assistance Program. These persons must demonstrate to the Department that their household income and resources do not exceed the income and resource standards established by the Department such standards being equal to or more restrictive than those for the Aid to Families with Dependent Children (AFDC) program.

Medical assistance recipients 21 years of age or older but under 65 years of age who receive services in Institutions for Mental Diseases (IMD), who have been determined eligible for Supplemental Security Income (SSI) benefits, and who are not otherwise eligible for Federal financial participation for the IMD services, also qualify as low income individuals subject to the provisions of the Federal disproportionate share statute, Section 1923 of the Social Security Act (42 U.S.C. § 1396r-4), and payments made to an IMD on their behalf are disproportionate share payment adjustments.

Each hospital will determine those patients who qualify as low-income persons eligible for additional payments by a verifiable process subject to the eligibility conditions set forth above. Each hospital must maintain documentation of the patients' eligibility for additional payments and must document the amounts claimed for additional payments.

A disproportionate share hospital for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards as set forth above. Notwithstanding this, no hospital shall be deemed to be a disproportionate share hospital unless it has a Medicaid inpatient

utilization rate of not less than one percent. In addition, a disproportionate share hospital (except hospitals serving an inpatient population predominately comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care in services to Medicaid-eligible patients on a non-emergency basis.

The amount of the disproportionate share adjustment varies by hospital and reflects the dollar amount of payments by either the State directly or an intermediary to the hospital for services provided to low-income patients. For each hospital, such adjustment shall be paid in the normal medical assistance or intermediary payment process and according to rates or fees established by the Commonwealth for fee-for-service program services or by the intermediary for its services. To receive payment of this adjustment, each hospital must submit a claim in the form and manner specified by the Commonwealth or the intermediary, as appropriate.

Disproportionate share payments under this plan cannot exceed the State disproportionate share allotment calculated in accordance with the provisions of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234), as set forth at 42 CFR Sections 447.296 through 447.299.

AUGMENTED PAYMENTS FOR CERTAIN HIGH MEDICAL ASSISTANCE HOSPITALS

For Fiscal Year 1993-94 and FY 1994-95, the Department will make payments to certain high medical assistance hospitals to assure their participation in the Medical Assistance Program. For a hospital to qualify for such payments, the hospital must meet all of the following criteria:

1. At least 60 percent of the hospital's days of care must be provided to medical assistance recipients as reported in the hospital's FY 1991-92 medical assistance cost report.

2. The hospital must provide a broad spectrum of inpatient services as evidenced by its enrollment in the Medical Assistance Program as of June 30, 1993, as an acute care general hospital with at least two of the following types of excluded units enrolled:

a) an excluded psychiatric unit;
b) an excluded drug & alcohol detox/rehabilitation unit; or
c) an excluded medical rehabilitation unit.

3. The hospital's liabilities exceed its assets as verified by the hospital's independently audited financial statements for FY 1991-92.

Hospitals qualifying under these criteria are eligible for payments at a level adequate to assure the hospital's continued participation in the Medical Assistance Program and the continued availability of these services to the medical assistance population.

A distressed hospital qualifying under this provision will receive additional payments under Attachment 4.19A so that total medical assistance payments to the hospital equal the hospital's projected total cost of treating medical assistance and uncompensated care patients.

This augmented payment policy terminates effective July 1, 1995.

CHANGES OF OWNERSHIP

Effective July 1, 1993, no provider may have its rates rebased solely due to change of ownership.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT HOSPITAL CARE

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.